

Virtual Clinic OpenEyes for Nurses/Technicians and Health Care Assistants

(User Manual)

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Aims

This session is designed to introduce delegates to OpenEyes by presenting Healthcare professionals the technology to be able to document the clinical journey of patients under their care. The session aims to give the best practices on better patient care and management.

The Nurse/ Technicians /Health Care Assistants will use mainly episode and events screen within OpenEyes for diagnosis, examinations and prescriptions.

The following features are included in this course:

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Documentation History

Date	Version number	Revision details	Written by	Approved by
24/11/2014	0.1	First draft of document	Victoria Aina	OpenEyes Programme Office
29/01/2014	0.2	Removal of Virtual Clinic screen shots and access description. Description of how to add patients to VC list.	Victoria Aina	OpenEyes Programme Office and

Document Status

This is a controlled document.

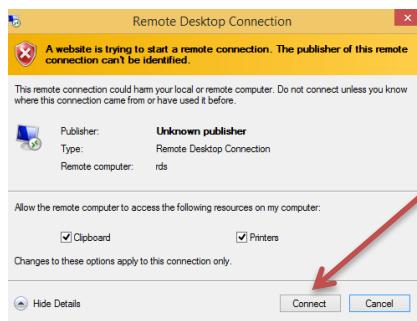
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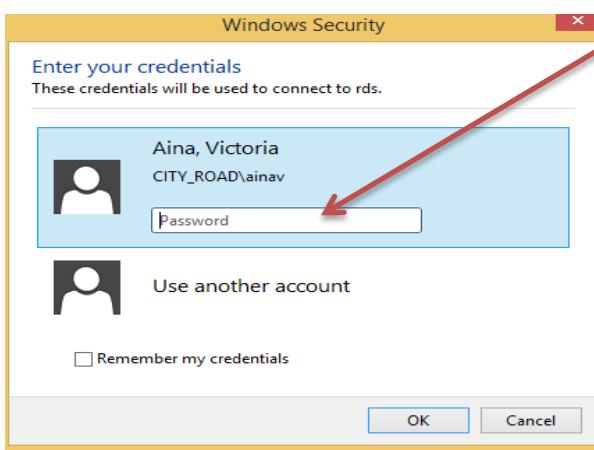
Logging on and Getting Started

The OpenEyes login page is case sensitive.

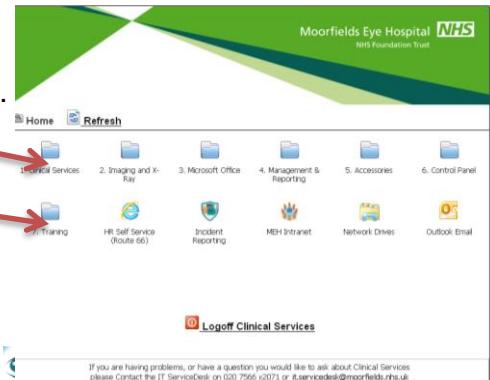
1. Select the clinical services link within the intranet.
2. The remote desktop pop up box opens, select the grey **Connect** button situated within the box.



3. Within the Window Security pop up box enter '**Password**'.



4. Select Clinical services folder (for the live environment).



5. Select the Training folder (Training environment).



6. Launch **Open Eyes** by selecting (double clicking) the **OpenEyes Training** Icon.



7. Delegates will now have entered the OpenEyes page and be able to view the login page.



8. Enter Username and Password then select the blue login button **Login**.

Overview of Patient Summary Screen

If demographic details need to be altered, this action can currently be altered/updated in PAS.

The screenshot shows the OpenEyes Patient Summary screen. At the top, there is a header with the OpenEyes logo, a 'CLOSE' button, and a 'Patient Summary' link. The main content area is divided into several sections:

- Patient Demographics:** Shows personal details (First name: Chay, Last name: Close, Address: Unknown, Date of Birth: 2 Nov 1920, Age: 93, Gender: Female, Ethnic Group: Unknown), contact details (Telephone: 04130 4541610, Email: Unknown), and associated contacts (Unknown).
- All Episodes:** A table showing a list of episodes arranged by speciality. The table has columns for Start Date, End Date, Firm, Subspecialty, Eye, and Diagnosis. The data includes:

Start Date	End Date	Firm	Subspecialty	Eye	Diagnosis
20 Dec 2011		Abou-Rayyah Yassir	Adnexal	Both	Chalazion
17 Jan 2012		Andrews Richard	Medical Retinal	Left	Malignant melanoma of choroid
14 Apr 2013		Brookes John	Glaucoma	Left	Pigmentary glaucoma
3 Jun 2013		Allan Bruce	Cataract	Left	Aphakia
31 Jul 2013		Allan Bruce	External	No diagnosis	No diagnosis
22 Oct 2013		Aylward Bill	Vitreoretinal	Both	Macular hole
- Latest Event in Glaucoma Prescription (17 Apr 2013):** A link to the latest event in the glaucoma prescription.
- Other ophthalmic diagnoses:** A table showing ophthalmic diagnoses with columns for Date, Diagnosis, and Actions (Remove). The data includes:

Date	Diagnosis	Actions
14 Apr 2013	Right Age related macular degeneration	Remove
14 Apr 2013	Right Low tension glaucoma	Remove
14 Apr 2013	Right Pigment dispersion syndrome	Remove
14 Apr 2013	Right Acute angle-closure glaucoma	Remove
14 Apr 2013	Right Secondary glaucoma	Remove
2014	Right Acute angle-closure glaucoma	Remove
- Add Ophthalmic Diagnosis:** A button to add a new ophthalmic diagnosis.
- Systemic Diagnoses:** A table showing systemic diagnoses with columns for Date, Diagnosis, and Actions (Remove). The data includes:

Date	Diagnosis	Actions
2013	Diabetes mellitus type 1	Remove
14 Apr 2013	Myocardial infarction	Remove
14 Apr 2013	Marfan's syndrome	Remove
14 Apr 2013	Marfan's syndrome	Remove
- Add Systemic Diagnosis:** A button to add a new systemic diagnosis.
- Previous ophthalmic surgery:** A table showing previous ophthalmic surgery with columns for Date, Operation, and Actions (Edit, Remove). The data includes:

Date	Operation	Actions
16 Oct 2013	Right Cataract surgery	Edit Remove
- Add Previous ophthalmic surgery:** A button to add a new previous ophthalmic surgery.
- Medication:** A table showing current medication with columns for Medication, Administration, Date, Actions (Edit, Stop, Delete), Adherence, Comments, and Actions (Edit). The data includes:

Medication	Administration	Date	Actions	Adherence	Comments	Actions
Acetazolamide 250mg tablets	1 tablet(s) PO qid	22 Aug 2014 -	Edit Stop Delete	Not Recorded	Not Recorded	Edit
- Add Medication:** A button to add a new medication.

Patient demographics

Patient 'Episode/s' of care arranged by speciality'

Links takes you to last event recorded.

Patient Clinical Summary.

Minimum Legacy Data Set.

Inform delegates that it is expected that doctors and optometrists enter the minimum legacy data sets into the relevant fields located on the summary page.

Ophthalmic Diagnosis

Other ophthalmic diagnoses		
Date	Diagnosis	Actions
14 Apr 2013	Right Age related macular degeneration	Remove
14 Apr 2013	Right Low tension glaucoma	Remove
14 Apr 2013	Right Pigment dispersion syndrome	Remove
14 Apr 2013	Right Acute angle-closure glaucoma	Remove
14 Apr 2013	Right Secondary glaucoma	Remove
2014	Right Acute angle-closure glaucoma	Remove

Add Ophthalmic Diagnosis

1. Select the **Add Ophthalmic Diagnosis** button.
2. From the list of 'Commonly used diagnosis' linked to the speciality (firm) select appropriate diagnosis or Select a SNOMED term by typing into the dynamic text box .

Diagnosis:

or type just few characters of a diagnosis

Eye: Right Both Left

Date diagnosed:

Save **Cancel**

3. Enter date of diagnosis.
4. Select the green **Save** button to save diagnosis entered.
5. Select **Cancel** to discard information entered in the diagnosis area.

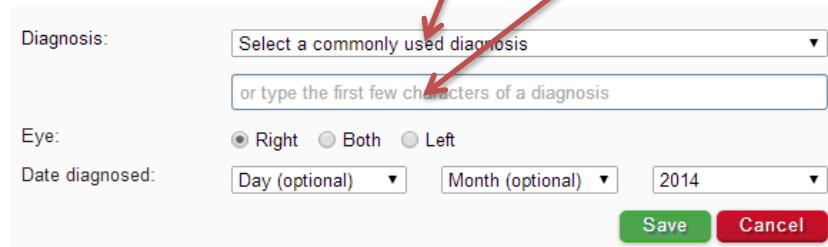
Systematic Diagnosis

1. Select **Add Systemic Diagnosis** button.

Systemic Diagnoses		
Date	Diagnosis	Actions
2013	Diabetes mellitus type 1	Remove
14 Apr 2013	Myocardial infarction	Remove
14 Apr 2013	Marfan's syndrome	Remove

Add Systemic Diagnosis

2. Select the appropriate '**Commonly used diagnosis**' linked to the speciality (firm) from the drop down menu or Select a SNOMED term by typing into the dynamic text box.



Diagnosis:

or type the first few characters of a diagnosis

Eye: Right Both Left

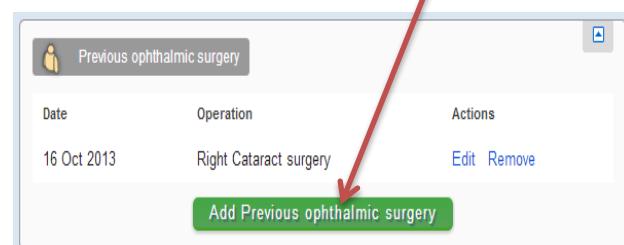
Date diagnosed:

3. Enter date or diagnosis.

4. Select the green **Save** button.

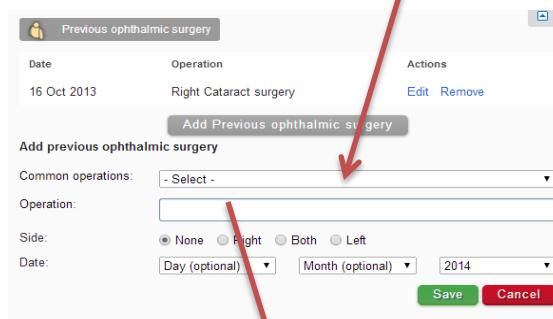
Previous Ophthalmic Surgery

1. Select **Add Previous ophthalmic surgery** button.



Date	Operation	Actions
16 Oct 2013	Right Cataract surgery	Edit Remove

2. Select the appropriate '**Common operations**' option from the drop down menu or enter free text in the '**Operation**' box below.



Date	Operation	Actions
16 Oct 2013	Right Cataract surgery	Edit Remove

Add previous ophthalmic surgery

Common operations:

Operation:

Side: None Right Both Left

Date:

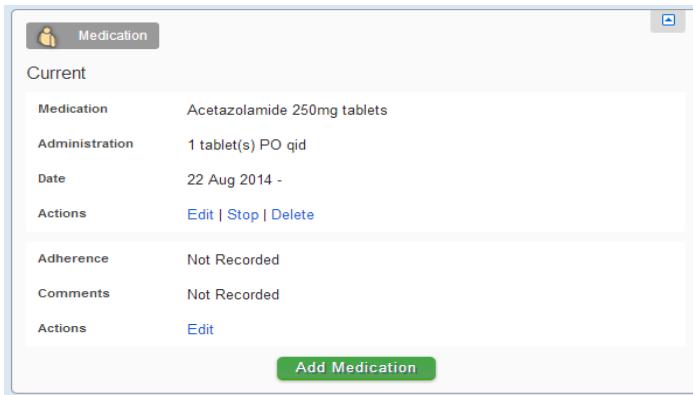
3. Select the appropriate '**side**' from the option of ariel circles. (*only select if appropriate*)

4. Enter the date of operation.

5. Select the green **Save** button.

Medication

1. Select the **Add Medication** button.



Medication

Current

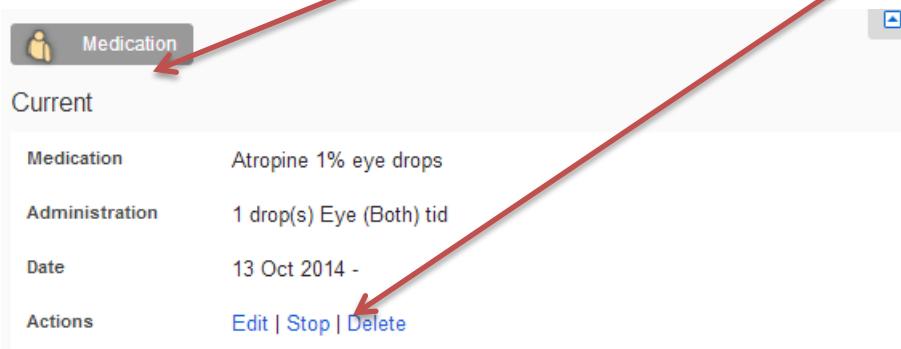
Medication	Acetazolamide 250mg tablets
Administration	1 tablet(s) PO qid
Date	22 Aug 2014 -
Actions	Edit Stop Delete
Adherence	Not Recorded
Comments	Not Recorded
Actions	Edit

Add Medication

2. Select medication from the drop down menu.
3. If the medication required is not listed, search the formulary in the dynamic field below and Select a SNOMED term by typing into the dynamic text field for any other.
4. Enter the patient dose. *This field is free text*
5. Select the appropriate 'route' from the drop menu.
6. Select the appropriate 'frequency' from the drop down menu.
7. Select date patient began using medication or select todays date by clicking the 'Blue button' located on the right hand side of the box.
8. Select current state of medication. *Is the patient currently using the medication.*

Stop, Edit or Delete Medication

1. Within the medication box, under the 'current' subheading.
2. Identify the required medication.
3. Select the appropriate action from the 'Actions' field: **Edit|Stop|Delete**.



Medication

Current

Medication	Atropine 1% eye drops
Administration	1 drop(s) Eye (Both) tid
Date	13 Oct 2014 -
Actions	Edit Stop Delete

Stop

1. To 'Stop' medication ensure the following fields are completed, 'date stopped' and 'reason stopped' select the appropriate option from the drop down menu then select green **Stop** button .

Stop Medication

Add Medication

Medication: Atropine 1% eye drops

Date stopped: 13 October 2014

Reason for stopping: - Select -

Stop Cancel

2. The medication will move from the 'current' medication sub heading to the 'previous' medication subheading.

Medication	
Current	Atropine 1% eye drops 1 drop(s) Eye (Both) tid 13 Oct 2014 - Edit Stop Delete
Previous	Apraclonidine 0.5% eye drops 1 drop(s) Eye (Both) tid 13 Oct 2014 - 13 Oct 2014 Edit Delete

Add Medication

Edit

5. To 'Edit Medication' select 'edit' from action field.

Medication: Acetazolamide 250mg tablets

Dose: 1 tablet(s)

Route: PO

Frequency: qid

Date from: 22 August 2014

Current: Yes No

From today

Save Cancel

6. Select the required 'medication' from the drop down menu or Select a SNOMED term by typing into the dynamic text box.
7. Select the green **Save** button located bottom left hand area of the medication area to save any changes.
8. Select the **Cancel** button located on the right hand side of the medication area not to save changes

Delete

1. To delete medication select 'delete' from action field.
2. From the pop up box, select the **Remove medication** red button from within the pop up box.

WARNING: This will remove the medication from the patient record.

Are you sure you want to proceed?

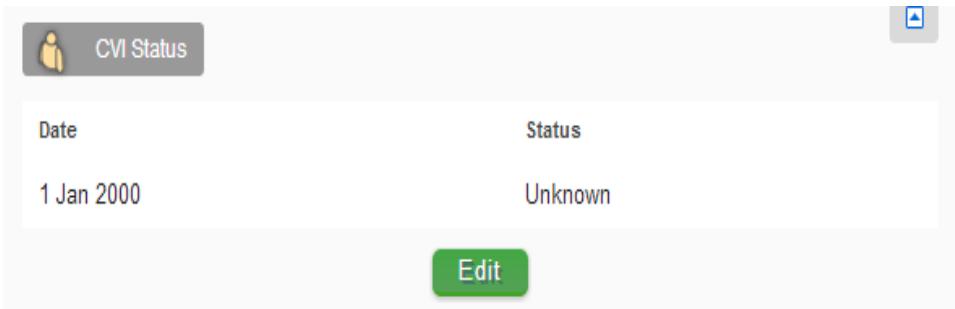
Remove medication Cancel

3. The medication will be removed from the list of medication.

CVI Status

Doctors are required to record the current visual impairment of their patient. Note a default date '1 Jan 2000' and status 'Unknown' is pre-populated in the fields.

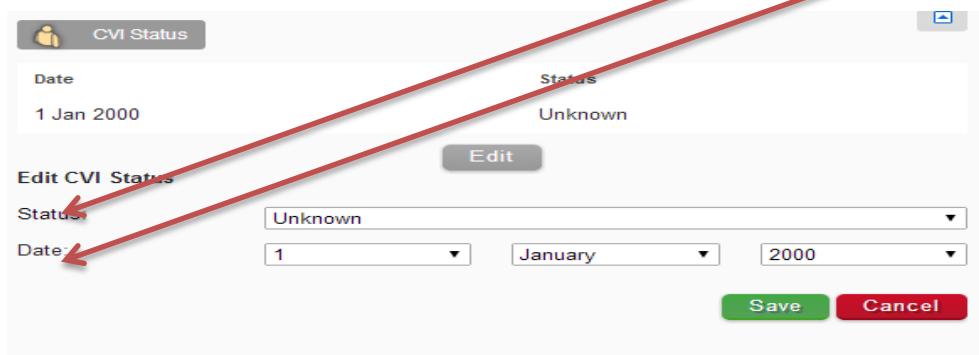
1. To add or edit the CVI status of a patient click on the green **Edit** button.



Date	Status
1 Jan 2000	Unknown

Edit

2. Under the 'Edit CVI Status' subheading complete the following fields '**Status**' and '**Date**' by selecting the appropriate fields from the drop down menu.
3. Select the green **Save** button so save changes.



Edit CVI Status

Date	Status
1 Jan 2000	Unknown

Status:

Date:

Edit **Save** **Cancel**

Allergies



Allergies

Patient allergy status is unknown

Edit

Within the 'Allergies' field select the green **Edit**

1. Select the appropriate allergy from the 'Add allergy' field.



Allergies

Patient allergy status is unknown

Confirm patient has no allergies:

Add allergy:

Edit **Save** **Cancel**

2. Select the green **Save** button, to save changes.

Family History

1. To complete family history select the green **Add Family History** button.



A screenshot of a table titled 'Family History'. The table has columns: Relative, Side, Condition, Comments, and Actions. At the bottom of the table is a green button labeled 'Add Family History'.

2. select the appropriate options from the drop down menus to complete the following fields '**Relative**,' '**Side**' and '**Condition**'.

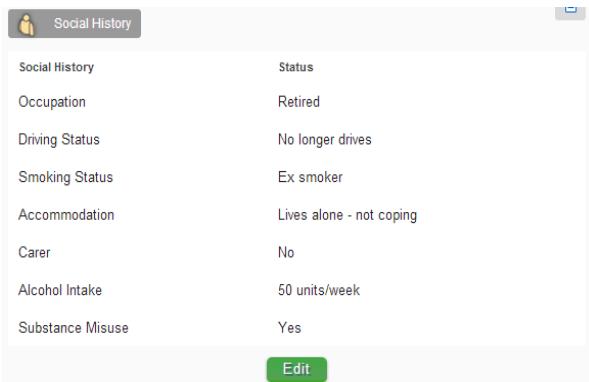


A screenshot of a dialog box titled 'Add family history'. It contains fields for 'Relative' (dropdown menu), 'Side' (dropdown menu, currently 'N/A'), 'Condition' (dropdown menu), and 'Comments' (text input field). At the bottom are 'Save' and 'Cancel' buttons.

3. Select the green **Save** button to save changes.

Social History

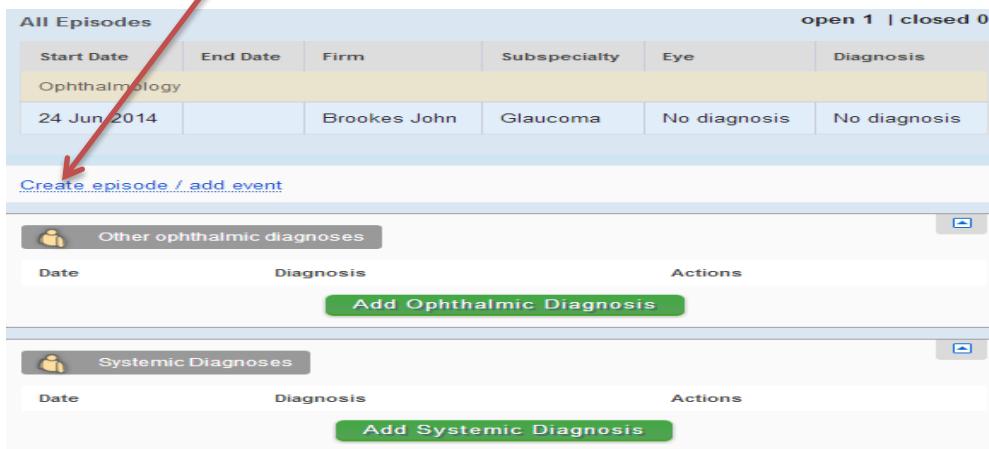
1. To complete the Social History select the green **Edit** button.



A screenshot of a table titled 'Social History'. The table has columns: Social History and Status. It contains the following data:
Occupation: Retired
Driving Status: No longer drives
Smoking Status: Ex smoker
Accommodation: Lives alone - not coping
Carer: No
Alcohol Intake: 50 units/week
Substance Misuse: Yes
At the bottom is a green 'Edit' button.

2. Select the appropriate option from the drop down menu to complete the following fields: '**Occupation**,' '**Driving Status**,' '**Smoking Status**,' '**Accommodation**,' '**Carer**,' and '**Substance Misuse**'
3. Complete the following free text fields: '**Comments**,' and '**Alcohol Intake**'.

4. On the right hand side of the main screen under the 'All Episodes' subheading select the blue 'Create episode/add event' link.



The screenshot shows the 'All Episodes' section of a clinical software. At the top, it says 'open 1 | closed 0'. Below that is a table with columns: Start Date, End Date, Firm, Subspecialty, Eye, and Diagnosis. One row is shown for 'Ophthalmology' with '24 Jun 2014' in the Start Date column, 'Brookes John' in Firm, 'Glaucoma' in Subspecialty, 'No diagnosis' in Eye, and 'No diagnosis' in Diagnosis. At the bottom left, there is a link 'Create episode / add event' with a red arrow pointing to it. Below this are two buttons: 'Add Ophthalmic Diagnosis' and 'Add Systemic Diagnosis'.

Episodes and Events

An episode is an on-going period of clinical care. A patient can have more than one episode of care at the same time at which point they may be under the care of a different consultant/and or speciality (firm).

An 'Open Episode' (current) has a start date but no end date. A 'Closed Episode' has a start and end date. This represents a period of clinical care that has now finished for a particular specialism(firm) led by a specific consultant.



The screenshot shows the 'All Episodes' section with 'open 3 | closed 0'. The table has columns: Start Date, End Date, Firm, Subspecialty, Eye, and Diagnosis. The first row (highlighted in yellow) is for 'Ophthalmology' with '8 May 2013' in Start Date and 'Brookes John' in Firm. The second row is for 'Hamilton Robin' with '23 Jul 2013' in Start Date and 'Medical Retinal' in Subspecialty. The third row is for 'Maurino Vincenzo' with '30 Oct 2013' in Start Date and 'Cataract' in Subspecialty. Red arrows point to the 'Start Date' and 'End Date' columns in the table header.

An Event is any activity that takes place during a patient appointment e.g.; booking a procedure, examinations, Clinic letters. This is recorded within open eyes.

Episodes and Events' summary screen

1. The 'Episodes and Events' summary screen opens.

Summary

Glaucoma

Overview

Male, 44, CVI status: Sight Impaired, Driving status: No longer drives

Principal diagnosis:

Primary angle-closure glaucoma

Principal eye:

Right

Refraction

0.00/0.00 @ 176° Ophthalmologist 0.00/0.00 @ 0° Auto-refraction

CCT

Not recorded Not recorded

IOP1

10 mmHg 13 mmHg

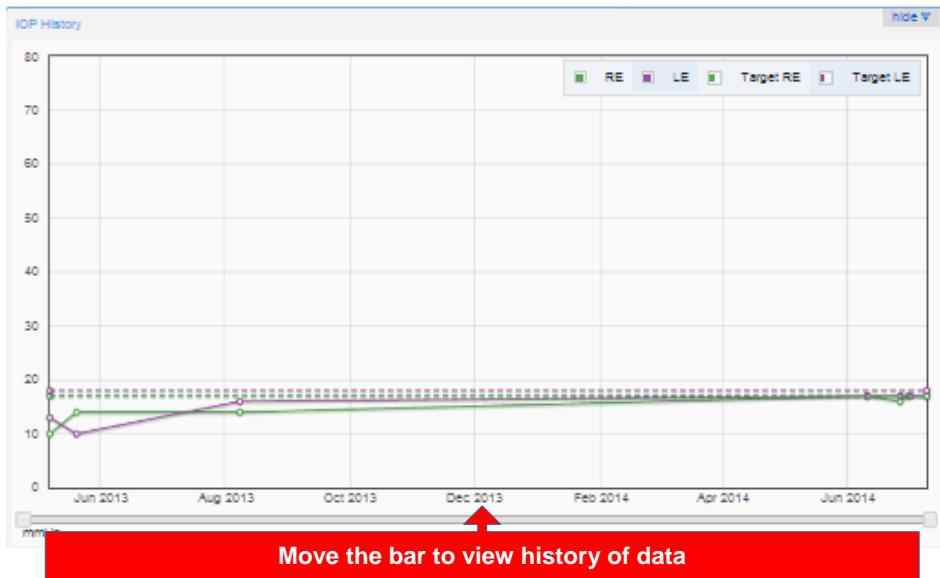
Glaucoma Management Plan

Clinic Interval	12 months
Photo	12 months
OCT	12 months
Visual Fields	12 months
Gonio	Not required
HRT	12 months

The 'Summary Screen' displays the following information:

- Overview
- Principal Diagnoses
- Refraction
- CCT
- IOP
- Comments
- Clinic Interval
- Investigations
- Visual Field progression and last Visual fields
- Glaucoma Management Plan extracts
- Target IOP

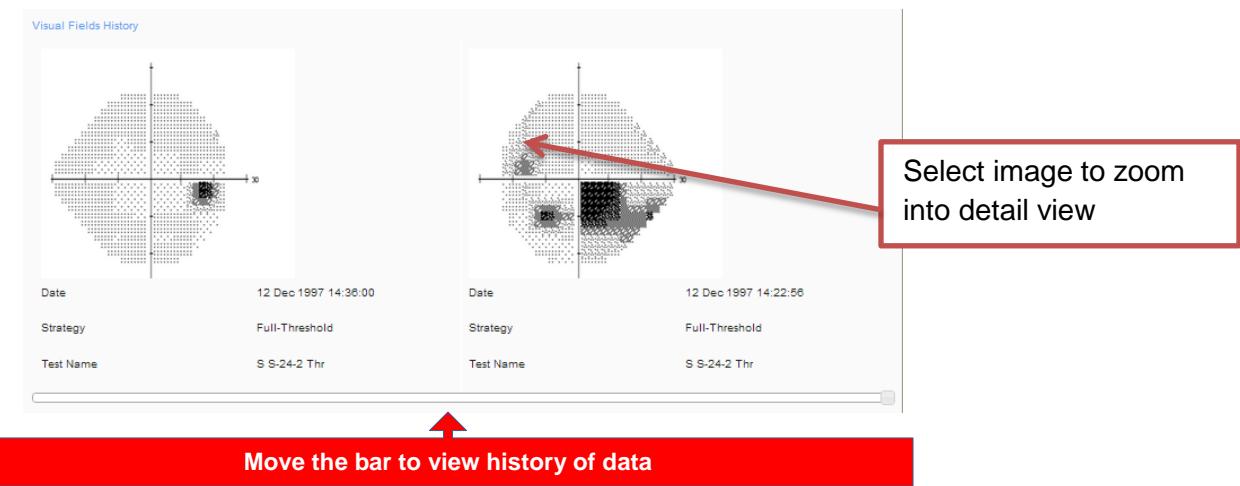
Graph of IOP History



Graph of Visual Acuity History



Visual Fields History



Episode Details

Start Date:	4 Jun 2014	End date:	(still open)
Subspecialty:	Glaucoma	Consultant firm:	Brookes John
Glaucoma: created by User User on 4 Jun 2014 at 12:43			
Episode Status:			
Post-op			

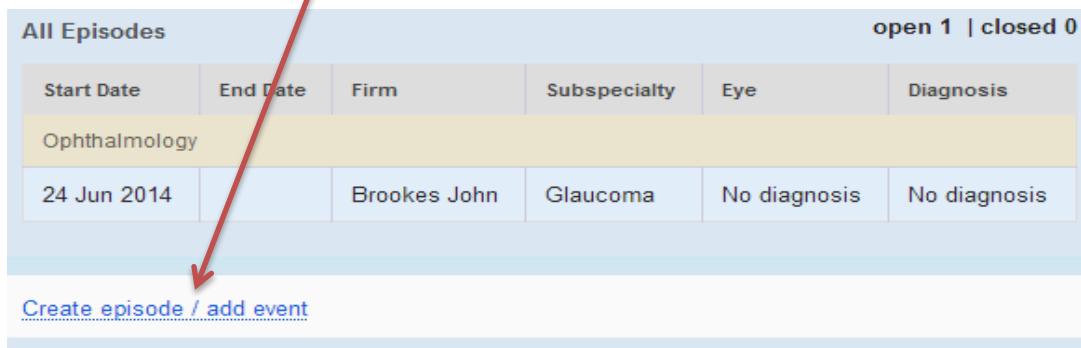
View episode details

View episode status

How to create an Episode

How an Episode is created is dependent on the screen. If creating an Episode from the 'Patient Summary' screen follow from step 1. If already in the 'Episodes and Events' summary screen follow from step 2.

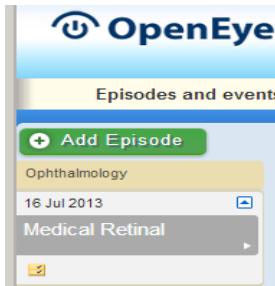
1. On the right hand side of the 'Patient Summary' screen under the 'All Episodes' sub [Create episode / add event](#) link.



Start Date	End Date	Firm	Subspecialty	Eye	Diagnosis
24 Jun 2014		Brookes John	Glaucoma	No diagnosis	No diagnosis

Create episode / add event

2. From the 'Episodes and Events' summary screen select [+ Add Episode](#) located on the left hand side of the screen.



OpenEye

Episodes and events

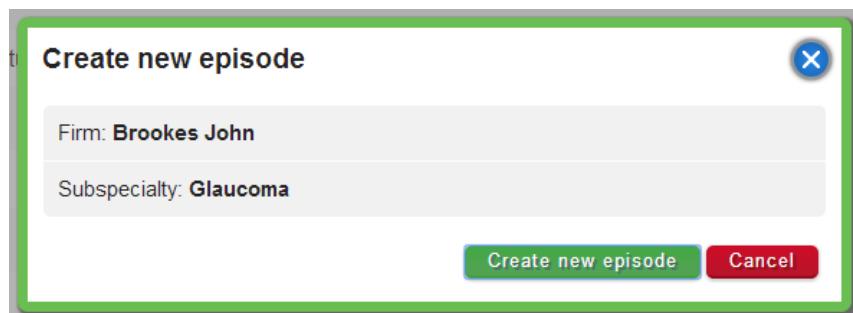
+ Add Episode

Ophthalmology

16 Jul 2013

Medical Retinal

3. Select the green [Create new episode](#) button from the 'Create new episode' pop up box to create new episode of care.



Create new episode

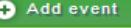
Firm: Brookes John

Subspecialty: Glaucoma

Create new episode Cancel

How to create an Event

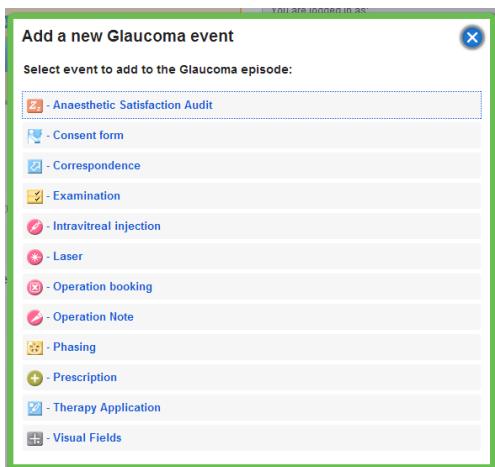
Ensure the correct firm/episode has been selected before adding or changing an event.

1. To the left of the Episodes and Events summary screen select the green  button, to add a patient 'Event.'

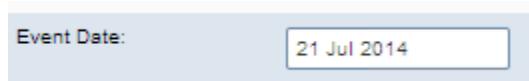


2. Select the  - **Examination** option from the 'Add a new event' pop up box.

Depending on episode of care chosen this box subheading will display a different speciality.

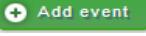


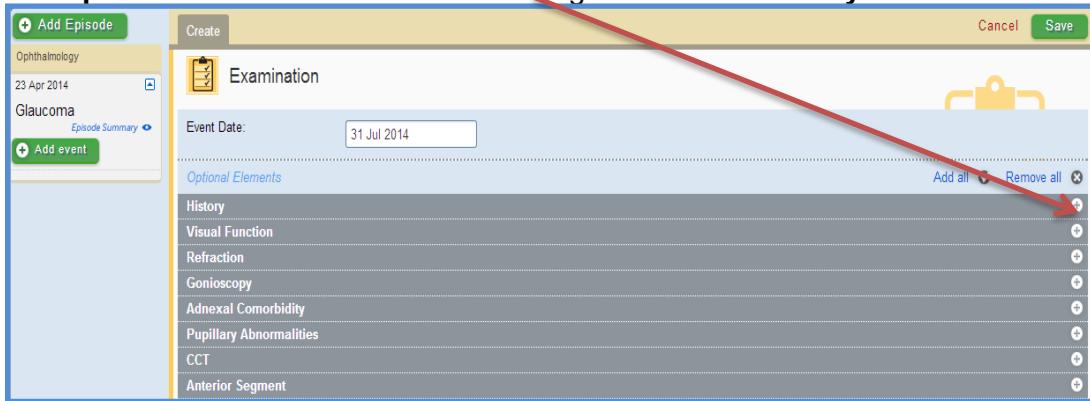
3. Change date to record for an event retrospectively these events will appear.



History Examination

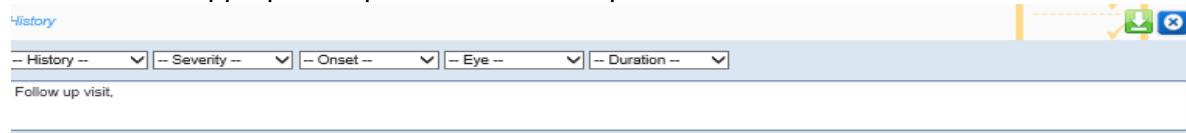
Complete Step 3 if 'History' area of the examination form is not already open.

1. To the left of the Episodes and Events summary screen select the green  button, to add a patient event.
2. The 'Examination' form opens. To add the 'History' data scroll down to the grey 'Optional Elements' and select the + sign beside the 'History' label



The screenshot shows the 'Examination' form. On the left, there's a sidebar with 'Add Episode' and 'Ophthalmology' sections. The main area has a 'Create' button at the top right. Below it is a 'History' section with a date field set to '31 Jul 2014'. A 'Optional Elements' section follows, containing a list of items: History, Visual Function, Refraction, Gonioscopy, Adnexal Comorbidity, Pupillary Abnormalities, CCT, and Anterior Segment. Each item has a '+' sign to its left. A red arrow points to the '+' sign next to 'History'. At the top right of the main area are 'Cancel' and 'Save' buttons.

3. The 'History' area of the examination form opens.
4. Select the appropriate options from the drop down menu or free text to enter the



The screenshot shows the 'History' data entry screen. It features a header with dropdown menus for 'History', 'Severity', 'Onset', 'Eye', and 'Duration', and a 'Follow up visit' text input field. Below the header is a large text area for entering history details.

5. Select the green  button on the top right hand side of the examination screen to save information entered.
6. Select  to discard information entered

Visual Function Examination

Complete Step 3 if 'Visual Function' area of the examination form is not already open

1. To the left of the Episodes and Events summary screen select the green  button, to add a patient event.
2. The 'Examination' form opens. To add 'Visual Function' examination data scroll down to the grey 'Optional Elements' and select the + sign beside the 'Visual Function' label to enter data for 'Visual Function'.
3. The 'Visual Function' area of the examination form opens.
4. Enter information in the 'Visual Function' comment box area.



The screenshot shows the 'Visual Function' examination form. It has a header with a 'Visual Function' label and a 'RAPD' checkbox. Below the header is a large text area for comments, which contains the text 'I'. At the bottom left, there's a 'Page |' label.

5. Select the green **Save** button on the top right hand side of the examination screen to save information entered.
6. Select **Cancel** to discard information entered that is no longer required.

Visual Acuity Examination

Complete Step 3 if 'Visual Acuity' area of the examination form is not already open

1. To the left of the Episodes and Events summary screen select the green **+ Add event** button, to add a patient event.
2. The 'Examination' form opens. To add 'Visual Acuity' examination data scroll down to the grey 'Optional Elements' and select the + sign beside the 'Visual Acuity' label to enter data for 'Visual Acuity.'
3. The 'Visual Function' area of the examination form opens.

4. Select the appropriate option from the 'Visual Acuity' drop down menu.

5. Select the appropriate 'Visual Acuity' value from the drop down menu.

6. Select the appropriate option from the drop down menu.

7. Select the green **Save** button on the top right hand side of the examination screen to save information entered.
8. Select **Cancel** to discard information entered that is no longer required.

CCT examination

1. To the left of the Episodes and Events summary screen select the green **+ Add event** button, to add a patient event.
2. The 'Examination' form opens. To add CCT examination data scroll down to the grey 'optional elements' and select the + sign beside the CCT label to enter data for CCT.

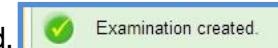
The screenshot shows the 'Examination' form. On the left, there's a sidebar with 'Add Episode' and 'Episode Summary' buttons. The main area has a 'Create' button at the top. Below it, there's a section for 'Event Date' (31 Jul 2014) and a 'Optional Elements' list. The 'Optional Elements' list includes: History, Visual Function, Refraction, Gonioscopy, Adnexal Comorbidity, Pupillary Abnormalities, CCT, and Anterior Segment. The 'CCT' item is highlighted with a red circle. At the top right of the form are 'Cancel' and 'Save' buttons.

3. The 'CCT' area of the examination form opens. Complete the necessary fields.

If both eyes are not being examined select the X button to close the eye examination field of the eye that is not being examined.

The screenshot shows the CCT examination form. It has two sets of fields for eye examination. Each set includes a dropdown menu with 'Ultrasound pachymetry' and a close (X) button. The close buttons for both sets are circled in red. At the bottom right of the form is a 'Save' button.

4. To save information entered select the green **Save** button located top right hand corner of the examination form.
5. Once saved the following message will be displayed.



Intraocular pressure Examination

Follow step 1 if 'Intraocular Pressure' area of examination screen not already open. If open follow from step 2.

1. To add the data from 'Intraocular Pressure' examination scroll down to the grey 'optional elements' and select the + sign beside the 'Intraocular Pressure' label.
2. Select the green **Add** button located bottom left hand side of the 'Intraocular pressure' area of the screen.

Time	mm Hg	Instrument
15:24	10	Goldmann
15:24	Soft	Palpation

Add

Empty text box for comments.

3. Enter the mm Hg data.
4. Select the appropriate instrument.
5. Record any relevant comments into the box below.
6. Select the green **Save** button on the top right hand side of the examination screen to save information entered.
7. Select **Cancel** if information entered is not required to be saved.

Dilation

Follow step 1 if 'Dilation' area of examination screen not already open. If open follow from step 2.

Multiple dilation drugs can be recorded select add to enter additional dilatation.

1. To add the data from the 'Dilation' examination scroll down to the grey 'optional elements' and select the + sign beside the 'Dilation' 'tab'.
2. To record the data of the drops administrated to patient, select the appropriate drug from the drop down menu.

Time	Drug	Drops
12:03	Atropine 1%	2

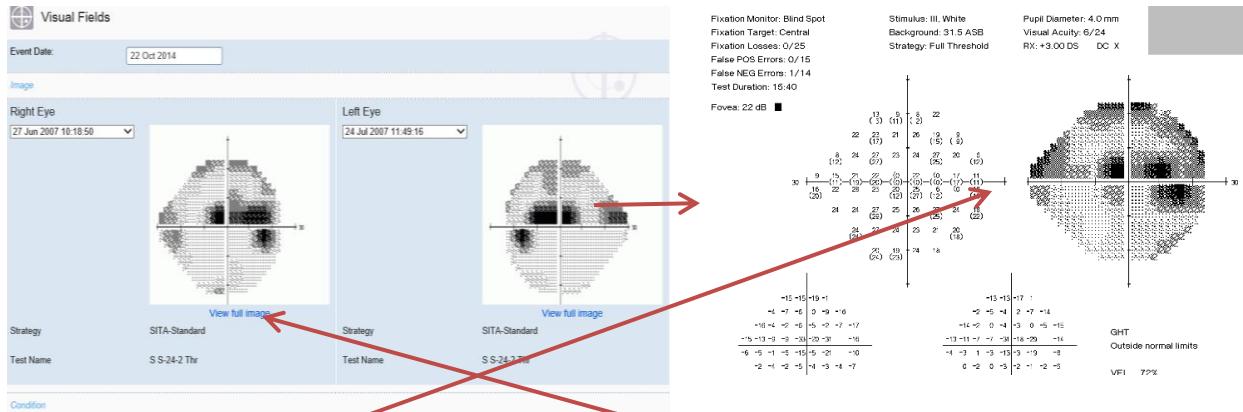
3. The time of administration is set automatically to the current time. To change click into the time box and type desired time to override the default time.
4. Select the number of drops administrated from the drop down menu.
5. Select the green **Save** button on the top right hand side of the examination screen to save information entered.

Visual Fields Legacy Event

Ensure the appropriate event date is recorded within the 'Event Date' field.

1. To the left of the Episodes and Events summary screen select the **+ Add event** and select the 'Visual Field' legacy Event.
2. The 'Visual Field' event screen opens.
3. Select the appropriate option from the 'Right Eye'/'Left Eye' drop down menu.

Only select options both eyes if historical image is required for both eyes.



4. To view the full image, select the 'view full image' hyperlink.
5. The 'image' will open in a separate screen.
6. Select the appropriate option from the 'ability' drop down menu.
7. Select the appropriate option from the 'Glasses' drop down menu.
8. Record any relevant comments in the 'Comments' box.

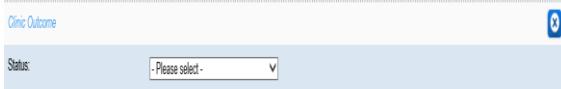
Ability:	- Please select -
Glasses:	<input type="radio"/> Yes <input type="radio"/> No
Comments:	
Result:	
Result Assessment:	- Please select -

9. Select the appropriate option from the 'Results' drop down menu.
10. Select the green **Save** button on the top right hand side of the examination screen to save information entered

Add patient to Virtual Clinic Patient list

Data Sets are displayed in the Clinic.

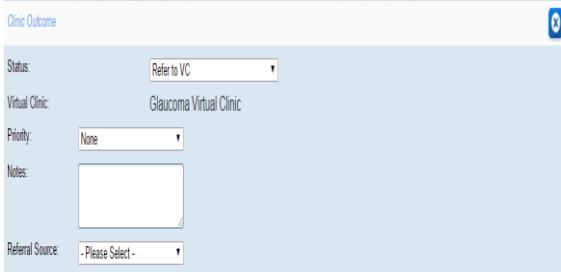
1. To add a patient to the 'Virtual Clinic' list scroll down to the grey 'optional elements' and select the + sign beside the 'Clinic Outcome' label.
2. Select the 'Refer to VC' option from the 'Status' drop down menu



Clinic Outcome

Status: - Please select -

3. A form opens. Select the appropriate priority (red, amber or green) option (as per clinic data sets) from the drop down menu.



Clinic Outcome

Status: Refer to VC

Virtual Clinic: Glaucoma Virtual Clinic

Priority: None

Notes:

Referral Source: - Please Select -

4. Select the appropriate option from the 'Referral Source' drop down menu.
5. Select the **Save** button located top right hand side of the examination screen to save information entered.
6. Select **Cancel** if information entered is not required to be saved

Logging Off

1. Select **Logout** from the tab located top right hand corner of the screen. *This can be seen from any screen within OpenEyes*

